



RESTRICTED-ACCESS DRUGS CERTIFICATION FAXBACK

FAX BOTH PAGES – INCOMPLETE FORMS MAY DELAY PROCESSING

ALL NC PROVIDERS MUST PROVIDE THEIR 5 DIGIT BCBSNC PROVIDER ID# BELOW

PRESCRIBER INFORMATION		PATIENT INFORMATION	
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME	
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID	
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH	
PRACTICE ADDRESS	CITY	STATE	ZIP

The nonpreferred drugs listed below require physician written certification. Coverage will be limited to the respective preferred agents unless written certification is provided by the physician stating that the patient meets the specific criteria listed in the signature box below.

DIAGNOSIS: _____

TRIPTANS – Use Triptan Restricted-Access and Quantity Limitations Fax Request Form

SSRI ANTIDEPRESSANTS

NONPREFERRED DRUG REQUESTED:

- Lexapro[®]
- Luvox CR[®]
- Pexeva[®]

PREFERRED DRUG(S) TRIED (Check at least one):

- Citalopram (generic or brand Celexa[®])
- Fluoxetine (generic or brand Prozac[®])
- Fluvoxamine (generic or brand Luvox[®])
- Paroxetine (generic or brand Paxil[®])
- Sertraline (generic or brand Zoloft[®])

HYPNOTIC AGENTS

NONPREFERRED DRUG REQUESTED:

- Ambien CR[®]
- Edluar[®]
- Lunesta[®]
- Rozerem[®]
- Zolpimist[®]

Note: Benefit limits may apply to preferred and nonpreferred hypnotic agents.

PREFERRED DRUG(S) TRIED (Check at least one):

- Zolpidem (generic or brand Ambien[®])
- Zaleplon (generic or brand Sonata[®])

PROTON PUMP INHIBITORS

NONPREFERRED DRUG REQUESTED:

- Prevacid[®] 15, 30 mg Solutabs; granules for oral susp
- Zegerid[®]
- Protonix[®] 40 mg suspension
- Aciphex[®]
- Dexilant[™] (Kapidex[™])
- Prilosec[®] for oral suspension (packets)
- Lansoprazole powder (powder for compounding only; doesn't include Prevacid brand products)

PREFERRED DRUG(S) TRIED (Check at least one):

- Omeprazole (generic or brand Prilosec[®], including Prilosec OTC)
- Pantoprazole (generic or brand Protonix[®])
- Lansoprazole (generic or brand Prevacid[®])
- Esomeprazole (Nexium[®])

INTRANASAL STEROIDS NONPREFERRED DRUG REQUESTED: <input type="checkbox"/> Beconase AQ [®] <input type="checkbox"/> Nasacort AQ [®] <input type="checkbox"/> Omnaris [®] <input type="checkbox"/> Rhinocort Aqua [®] <input type="checkbox"/> Veramyst [®]	<u>PREFERRED DRUG(S) TRIED (Check at least one):</u> <input type="checkbox"/> Flunisolide (generic or brand Nasarel [®]) <input type="checkbox"/> Fluticasone propionate (generic or brand Flonase [®]) <input type="checkbox"/> Mometasone furoate (Nasonex [®])
ORAL BIPHOSPHONATES NONPREFERRED DRUG REQUESTED: <input type="checkbox"/> Actonel [®] <input type="checkbox"/> Actonel [®] with Calcium	<u>PREFERRED DRUG(S) TRIED (Check at least one):</u> <input type="checkbox"/> Alendronate (generic or brand Fosamax [®]) <input type="checkbox"/> Alendronate / vitamin D3 (Fosamax Plus D [®]) <input type="checkbox"/> Ibandronate (Boniva [®])

Please certify the following by signing and dating below:

The above-referenced patient has previously used at least one of the preferred drugs in the pertinent drug class, as indicated above, and such drug has been detrimental to the patient's health or has been ineffective in treating the patient's condition and, in my opinion, is likely to be detrimental to the patient's health or ineffective in treating the condition again.

Prescriber's Signature Required: _____ Date: _____

Fax completed form to 1-888-348-7332